**Neuropathy Intake Form**

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social Security**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Age:** \_\_\_\_\_\_\_\_\_\_\_\_ **Sex:** **M F**

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Zip**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mobile Phone #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Home Phone #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Occupation (Current or Previous):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Retired: Yes / No**

**Current or Previous Work Type: Clerical – Y / N Light Labor – Y / N Moderate Labor – Y / N Heavy Labor – Y / N**

**Spouse’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Marital Status: S M D W # of Children**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**In Case of Emergency: Contact Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_

**How did you hear about our office?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What is your main health concern / condition coming in today?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Please check all that apply:*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| * **Foot Pain** | * **Low Back Pain** | * **Bulging Disc** | * **High Blood Pressure** | * **Neck Pain** |
| * **Foot Numbness** | * **Sciatica** | * **Joint Replacement** | * **High Cholesterol** | * **Morton’s Neuroma** |
| * **Foot Surgery** | * **Pinched Nerve** | * **Falls** | * **Diabetes** | **Last A1C: \_\_\_\_\_\_\_\_\_\_** |
| * **Leg Pain** | * **Herniated Disc** | * **Balance Issues** | * **Plantar Fasciitis** |  |
| * **Hand Pain** | * **Spinal Stenosis** | * **Poor Circulation** | * **Cancer** |  |
| * **Hand Numbness** | * **Spinal Arthritis** | * **Poor Wound Healing** | * **Chemotherapy** |  |
| * **Arthritis in Hands/Feet** | * **Degenerative Disc Disease** | * **Pacemaker/Defibrillator** | * **Implanted Cord / Bladder Stimulator** |  |

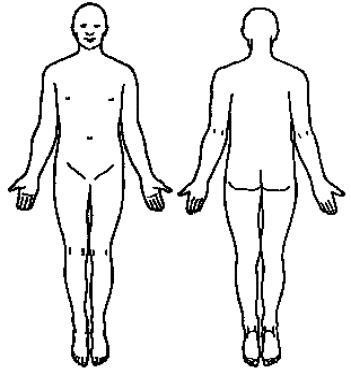
**When did this begin?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What makes it worse?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What makes it better?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**On a scale of 1 – 10; how committed and serious are you about fixing your condition?**

Not Serious 0 1 2 3 4 5 6 7 8 9 10 Totally Committed



**How would you describe your symptoms?** *(Circle any that apply)*

**| Sharp Pain | Stabbing Pain | Aching Pain | Throbbing Pain | Numbness | Tiredness |**

**| Heavy Feeling | Dead Feeling | Swelling | Electric Shocks | Pins & Needles | Tingling |**

**| Cramping | Imbalance / Falls | Burning | Hot Sensation | Cold Hands / Feet |**

**How would you describe the physical appearance of your feet / legs?** *(Circle any that apply)*

**| Discoloration of Skin | Dry / Flaky Skin | No Hair Growth | Discoloration of Toe Nail(s) | Loss of Toe Nail(s) |**

**| Cyanosis (Blue Coloring of Skin) | Petechiae / Red Spots | Blisters / Sores | Fungal | Other |**

Are your Symptoms over time *(Please Circle)* : Worsening Staying the Same Improving

**Frequency of your Pain:**

Constant (75-100%) \_\_\_\_ Frequent (51-75%) \_\_\_\_ Occasional (25-50%) \_\_\_\_ Intermittent (0-25%) \_\_\_\_

**On average what level would you rate your overall pain?**

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Possible

Is this condition interfering with any of the following? *(Circle any that apply)*

**| Daily Activities | Hobbies | Walking | Standing | Work | Sleep | Relationships | Sex Life |**



Please indicate on this drawing the area(s) where you are currently experiencing symptom(s):

**Please circle the things you have used / tried to relieve your symptoms:**

**| Gabapentin | Amitriptyline | Neurontin | Cymbalta | Lyrica | Opioids | Injections |**

**| Aleve / Naproxen | Tylenol / Acetaminophen | Advil / Ibuprofen | Motrin |**

**| Creams | CBD / Hemp Products | Chiropractic | Physical Therapy | Massage Therapy |**

**Other:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* I hereby authorize release of any medical information necessary to evaluate my case to .

**Name of your Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**May we contact them with updates regarding your treatment? Yes No**

**Please list any / all prescription medications you are currently taking (or you may attach a list):**

|  |  |  |
| --- | --- | --- |
| **Name** |  | **Dosage per Day** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Please list any / all allergies and sensitivities:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Please list any / all supplements (vitamins, herbs, homeopathic, etc.) you are currently taking:**

|  |  |  |
| --- | --- | --- |
| **Name** |  | **Dosage per Day** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Are you currently taking a Blood Thinner (Coumadin, Lovenox, Heparin, etc)? Yes No**

**Are you currently taking a Statin (Atorvastatin, Lipitor, Crestor, Simvastatin, etc)? Yes No**

**Do you drink alcohol? Yes No If yes, how many drinks per week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you smoke cigarettes? Yes No If yes, how many cigarettes daily? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you exercise regularly? Yes No If yes, please describe type & how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* I understand that cannot file the knee treatments to insurance at this time.
* will not enter into any dispute with your insurance company. If there is a discrepancy, it is the patients’ responsibility to contact their in insurance.

We invite you to discuss with us any questions regarding our services and or fees. The best health services are based on a friendly, mutual understanding between the provider and patient.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FUNCTIONAL GOALS SURVEY**

Please take several minutes to answer these questions so we can help you get better.

**How many doctors have you seen for this condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What medications/supplements/therapies/treatments did they prescribe/recommend for you?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Has what you’ve done to date for your condition helped?**

**☐ Yes, a lot** **☐ Yes, some** **☐ No, not at all** **☐ Indifferent**

**What are 3 – 5 activities you can no longer do or are struggling to do because of this condition?** *Please be specific.*

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What is your honest vision of your life in the next few years if this problem continues to progress? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**What would be different &/or better in your life without this problem? Please be specific.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**What is your biggest fear if this condition continues to progress? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**What would success mean to you in our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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